CITY OF SHEFFIELD EDUCATION COMMITTEE

SCHOOL HEALTH SERVICE

REPORT

of the

PRINCIPAL SCHOOL MEDICAL OFFICER
CLIFFORD H. SHAW, M.D., F.F.C.M , D.P.H., D.P.A.

and the

CHIEF EDUCATION OFFICER
G. M. A. HARRISON, M.A.

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REORGANISATION OF THE SCHOOL HEALTH SERVICE?

'I know just how to cure the world and make it safe and stable;
but I haven't time to do it, and those that have aren't able'
Leverett Lyon

Discussion documents on the future of the health services have appeared regularly since the first green paper of 1967, but only the scantiest reference has been made to the school health service. The second green paper listed the school health service as among the services to be administered by the area health authorities, but reserved judgment on the question of where responsibility for the child guidance service should be. In May, 1971, the Consultative Document appeared to put the whole of the school health service back in limbo by saying that future arrangements would require special consideration. Two months later the Scottish White Paper envisaged medical and dental examination and treatment becoming the responsibility of the health authority, but recognised that education authorities would continue to have a strong and continuing interest in the services provided: the child guidance service and the provision of speech therapy in schools would remain the responsibility of the education authority. Currently a sub-committee of a Working Party on Collaboration is considering the future of the school health service in England and Wales and presumably its conclusions will be published in due course.

Despite the reticence of official health sources, the Plowden Report (1967), on 'Children and their Primary Schools' gives some insight into thinking among educationalists, not so much on who does what, but on what should be done. It was considered that the responsibility of the school health service was to see that school children are not denied through un-recognised or untreated ill-health the opportunity to make the most of what school can offer; and to enable the educational systems to be adapted and modified to the needs and capacities of the child. School medical inspection enables unsuspected defects to be detected and incipient maladies checked at their onset, and furnishes the facts which will guide education authorities in relation to physical and mental development during school life. The function of the school health service is primarily preventive and advisory, and the improved facilities for treatment provided by the National Health Service means that the school health service should take up the challenge presented by the various environmental factors that disturb the development and learning of the children.

The Report finds it disquieting that an assessment is seldom made before the child goes to school, except when there is a severe mental or physical disability. Thus it is not possible to attempt any modification of the educational environment until after the child has been exposed to the risk of failure at an exceedingly vulnerable stage of life. However,

the child's needs cannot be met by a single examination, whether this is just before or just after the child's admission to school: supervision ought to be a continuing process, irrespective of the child's age and closer links should be forged with the family doctor and hospital paediatric services.

Disturbance in mental health of many children attending child guidance clinics has its origin during the formative years before a child first goes to school. Failure, either social or educational, may profoundly affect personality and produce behaviour disorders. A disturbed child comes so often from a disturbed family that local authority clinics are adopting increasingly a family approach to diagnosis and therapy, while maintaining their relationships with the schools.

Future trends in the school health service affecting primary school children should be towards the earlier identification of the less severe disabilities which impede growth, development and education, and an extension of screening procedures towards this end; a wider functional assessment of children around the age of school entry; a more complete assessment of handicapped pupils with regard as much for residual abilities as for primary disabilities; and a greater participation by school doctors and nurses in the management of incipient maladjustment and its prevention. In the necessary expansion of advisory work with teachers and parents of all children, but especially handicapped children, attention needs to be given to difficulties in emotional development that are associated with personal relationships as well as guidance regarding any specific disability when one is present.

The Society of Medical Officers of Health is concerned that the school health service is not definitely included in the proposals for a unified service. In its view the Area Health Authority should be responsible for the School Health Service, co-operating closely with the local education authority. The Society strongly opposes any suggestions that local government should run its own school health and dental service, separate organisationally from the National Health Service. Development screening of children should remain with, and be carried out by, doctors experienced in and convinced of the value of preventive and developmental paediatrics.

Doubtless other bodies will be pleading different cases. Until terms such as 'community physician' or 'community paediatrician' have been more clearly defined there is a danger of failing to distinguish between the clinical role as doctor and the organisational aspects of, for example, providing a series of screening tests in school; or meeting the medical, social and educational needs of a severely handicapped child through planning in concert with other members of a multi-discipline professional team.

Education authorities will be wary of ill-defined arrangements which are

at the discretion of consultant paediatricians whose training and experience is likely to be mainly in diagnostic and curative medicine. And yet, if integration of the health services is to be a reality, it would be unthinkable for a child health service to emerge lacking the stimulus of some form of association with hospital practice. From the standpoint of school doctor as clinician this means an opportunity to work in the wards and out-patient departments and, for the hospital doctor in training, periods of secondment to community service.

If, as is likely, it is decided that 'entrant' and 'leaver' examinations are to be continued, there may well be a place for married women doctors with family responsibilities employed to work at schools on a part-time sessional basis: similarly a greater number of family doctors may offer their services within this limited sphere. However, the more specialised aspects of the work would require doctors highly trained in developmental paediatrics, in touch clinically both with the hospital and perhaps also with doctors in group practice at health centres. It is likely that there will be fewer full-time doctors in the child health services but there should be more satisfying career prospects, without the need to find seniority in administrative posts.

Management is still necessary. There should be at least one doctor at area level with specific responsibility for child health on a community basis, fostering a partnership between paediatricians and other consultants, family doctors, nurses, psychologists, social workers and—not least—the teachers and the vast complex of supporting educational services. For the severely handicapped adolescent, however, continued guidance and encouragement is wanted as further education or training must be geared to job aptitudes and opportunities, and for this reason the balanced team created must continue to pilot the school leaver through the critical period of transition and, if necessary, must be supplemented in order to carry out this extended role until the age of 18 or 19 years. The school health service is not seen as a separate entity but as part of a wider health service for children and young people.

Minor ailment clinics survive as vestiges of the embryonic school medical services brought into being over sixty years ago to meet a situation quite different from that found in schools today. Whilst a service exists it will continue to be used. The better the service, the more it will be used and the more it may be considered indispensable. On the other hand it may be felt that the reorganisation of the health services is an opportune time to break with tradition, supporting the family doctor through the attachment of nursing staff at health centres and 'surgeries', and building up the first-aid facilities available in schools.

Whilst it would be possible to follow the vein of controversy along other branches of the School Health Service, it is difficult to imagine the organisation being uprooted or many boughs broken. Yet it is right to recognise the vulnerability of young shoots which may easily wither in a climate that fails to provide the necessary understanding. There is a danger of this not only in the association between health and education, but over the wide range of social and environmental services. The health and re-formed local authorities must feel the impetus of new life, taking a fresh look at the main purpose of their services and how best—having been separated—they can grow together again.

THE AUDIOLOGY SERVICES FOR CHILDREN IN SHEFFIELD

'This cuff was but to knock at your ear, and beseech listening,'
'The Taming of the Shrew' William Shakespeare

This contribution by Mr. J. T. Buffin is an adapted version of a paper read to a meeting of the Northern Branch of the British Society of Audiology in Sheffield in June 1971. This Society exists to foster closer co-operation between the many disciplines—medical, technical, scientific and educational—which combine to offer assistance to those who are deprived by deafness of the primary means of human communication. Deafness ranks among the most serious of the handicaps which may affect an individual at any age. Over the past 40 years there has developed a communal awareness and a common sense of responsibility for this problem.

Deafness in children is now the concern of medical and educational authorities. There is however no rigid pattern for the detection and management of deafness, and so there is much local variation in the way that this service is provided. These variations may reflect the physical amenities available locally, and they may reflect the character and enthusiasm of those who have worked in this field in the past to develop the present-day service. This paper outlines the system as it has grown, and as it now functions in the City of Sheffield, whereby we detect, diagnose, treat and educate our deaf children.

The hub of our system is the Audiology Clinic. This is a suite of rooms in a former school, now part of the Education Department, and in the centre of the city. The rooms are acoustically treated. They are basically nineteenth century schoolrooms and the result of this treatment is not ideal. But the advantages of a central position more than compensate for these minor shortcomings. The Clinic is readily accessible from most parts of the city and a single bus ride will bring our patients to within easy walking distance. As mothers often have other children at school and frequently bring pre-school brothers or sisters with them, ease of access is a great asset.

Furthermore, to have this clinic so closely associated with the idea of education, is a psychological advantage. The medical investigator not only confirms the mother's fears that her child is deaf, but in his history and enquiry he tends to aggravate the feelings of guilt which are such a burden to the parents of any handicapped child. To work away from the hospital and to start in a setting which represents hope for the future rather than regret for the past is, in my opinion, a distinct advantage.

The medical staff consists of a Senior Medical Officer and an Otologist.

The Senior Medical Officer has had training in audiology and in psychological medicine. Her duties include the administration of the Service.

They involve her with the Partially Hearing Units of the normal schools, and with the Maud Maxfield School for the Deaf. She visits the schools for the Mentally Handicapped, where there are hearing problems in children with multiple handicaps. It is the Senior Medical Officer who makes the initial assessment of very young children in whom deafness is known or suspected; and this is done in the Clinic.

The Otologist holds a weekly school session in the Clinic. Any ENT problem may be referred, but the clinic is mainly for school children with hearing problems. The cases are referred by school medical officers. Most come from the first school medical examination, either as a result of the audiogram or at the request of the parent. In any child where later deafness develops or is suspected by the teachers or parents, the audiogram is repeated. Although this clinic caters predominantly for the manifestations of catarrhal deafness, it is unusual for a clinic to pass without one and sometimes more cases with severe unilateral sensorineural hearing loss.

A special audiological clinic for severe sensorineural deafness is held once or more each term, depending on the number of cases to be seen. Children who have already been screened, are seen jointly by the otologist and the medical officer. The hearing loss is once again assessed and an effort is made to find the cause if this is not already known. The children receive an otological examination; and then their future prospects and plans are discussed with the parents. At this time a hearing aid is ordered for the child, and the mother is asked to bring it to the Clinic when the earmoulds are prepared.

Some of the cases present special difficulties—the child who is also retarded, or the child with some useful hearing whose educational placement is not clear. These children may be re-assessed jointly after an interval; the advice of the teacher of the deaf is also available.

The school nursing sisters associated with the Clinic are indispensable, organising the work, and performing pure tone audiograms, both for the school clinic and also checking on any doubtful audiograms from the school sweep tests. Audiograms are performed on any child by request. This may come from the school, the general practitioner or the parent. The same sisters go into the schools for the routine sweep test on all children in their second year at school.

The final regular member of the clinic team is the teacher of the deaf, who sees pre-school children regularly. A weekly visit is usual. At this stage she is not only teaching the child and its parents, but is also making a continual re-appraisal of the problem. The fact that she works in the clinic makes discussion with the medical officer a matter of routine, and in this way

further medical or administrative help is directly and readily available to her and so to the child. For example, the loan of speech trainers for use in the home is authorised on her recommendations.

This completes the description of the Audiology Service. It has been shown how a school child with deafness may be referred for advice and assistance. But how do the infants and pre-school children reach the clinic? For this group includes most of the real problem cases for the audiologist.

The child who is born deaf will in many cases receive initial audiometric assessment from his mother; for many mothers like to satisfy themselves that their baby can hear in the same way that they satisfy themselves that they can see, and that they have ten fingers and toes. If mother is in doubt, she may turn to grandmother or, if she is not available, to her general practitioner or to her health visitor.

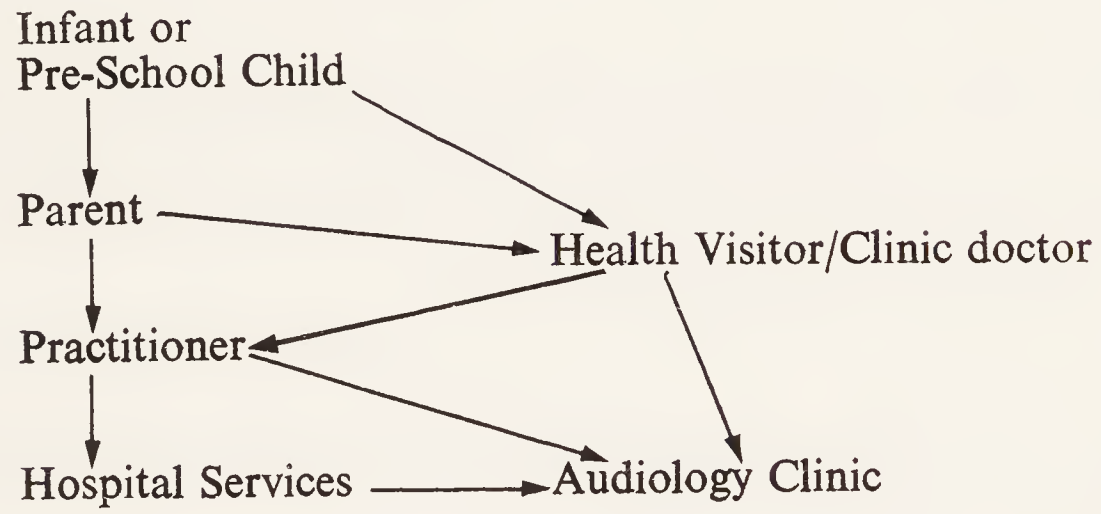
The general practitioner will probably satisfy himself by simple measures that there really is some evidence of defective hearing. In this case he may if he wishes refer the child directly to the Audiology Clinic. On the other hand, he may prefer to confirm the diagnosis through the hospital services, referring the child to the Paediatric or ENT departments. I hope that no practitioner today would tell the parents, as was done not so long ago, that they should wait until the child is older before anything can be done. The practitioner who is genuinely in doubt whether the child has any hearing loss, may also advise the parents to wait, and it is against this practice that we have to preach that any child suspected of deafness should have a full audiometric assessment at the earliest possible time.

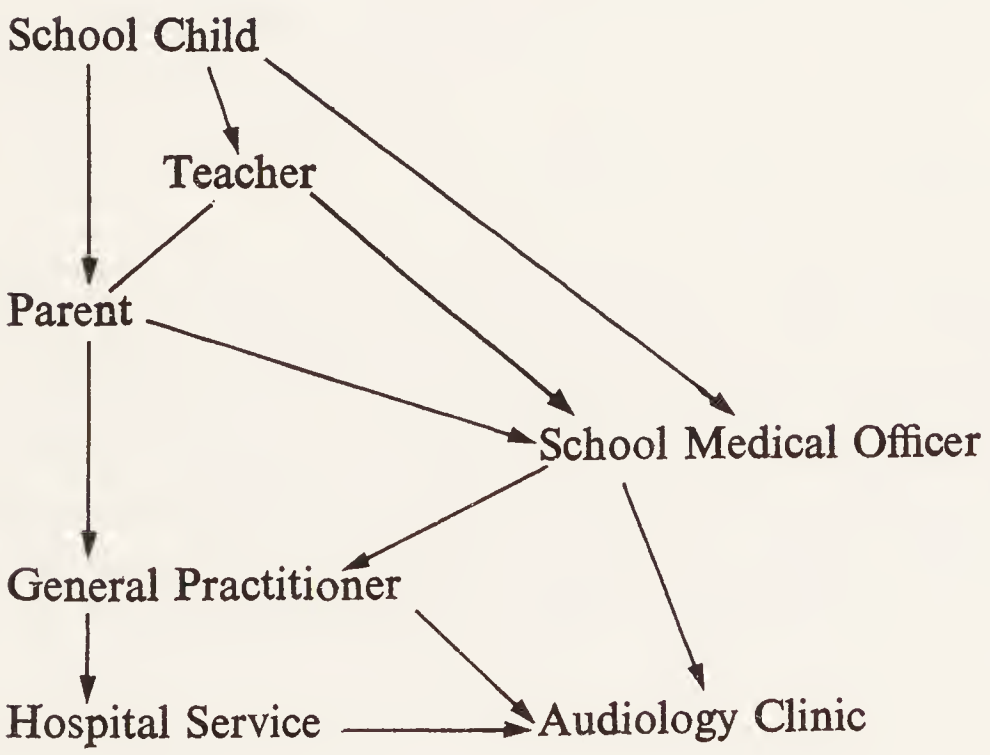
The health visitor and the maternity and child welfare services have a key role to play in the detection of deafness in infancy. The training of health visitors includes a lecture from the otologist, and lectures and demonstrations from the medical officer of the Audiology Clinic, and from the Department of Audiology of Manchester University. They are made aware of the possibility of deafness in any child. They know those groups of children whose hearing is particularly liable to be impaired—the children with a family history of deafness, the child of an abnormal pregnancy or difficult labour, and those various other conditions which are known as potential causes of profound childhood deafness.

The health visitor is shown how to test hearing in a baby by simple tests using materials which will be readily available to her. She is warned of the difficulties, and of the importance of separating auditory from other sensory stimuli. All children should be tested between the age of seven and nine months. Any doubtful cases are checked at the Audiology Clinic. All children who are known to be at special risk from the maternity records are referred in any case to the Clinic.

The Children's Hospital in Sheffield has its own Audiology Technician who tests all children referred to the various departments. Whichever department made the request for audiometry, those children who prove to be deaf are seen by an ENT Surgeon. Since the Otologist to the School Health Service is also one of the two Consultants on the staff of the ENT Department of the Children's Hospital, there is a close liaison between the work done there and at the Audiology Clinic. All children within the area covered by the Sheffield Education Department may be transferred directly to the Audiology Clinic for further help.

The work of the Service concerned with the detection and diagnosis of deafness in infancy and childhood may be summarised in these diagrams:—





This double screening programme at seven months and six years of age provides the Audiology Clinic with most of its clinical material. The child born severely deaf rarely escapes the net, and the milder cases are detected before their hearing loss can seriously affect their education.

There is a gap. Some children develop deafness in early childhood. In these cases, the onset may be related to an obvious cause, such as measles or meningitis; or it may be that there is no cause evident. Ideally there should be regular tests of hearing and such an examination is included as part of the routine developmental assessment examinations at child welfare clinics. In 1971, health visitors and clinic doctors referred 180 pre-school children, of whom 148 were over 1 year of age; 53 at least had speech defects. It is this group which will include the children with delayed onset of speech, and which forms the basis of our advice to medical students and general practitioners that any child who is not talking by the age of two years should be tested for hearing impairment. This group quite often presents at the Paediatric clinic rather than to the otologist; and it is often the Speech Therapist who first draws attention to deafness as the cause of the speech problem.

The reason for this gap in the screening programme is understood best if the size of the problem is appreciated. A brief statistical survey illustrates the extent of the task which all communities of a similar size do face with this type of screening programme.

The population of Sheffield is about 500,000. A stable community of this size will produce about 8,000 births each year. On this basis there should be about 40,000 children under the age of five and approximately 88,000 children aged five to sixteen.

A national survey has shown that the incidence of severe impairment of hearing is 6 out of every 10,000 school children. In Sheffield we would expect on average to detect 5 new cases each year, to have about 10 deaf children receiving pre-school auditory training, and 70 children in schools designed to meet the demands of the deaf child.

These predicted figures do agree quite closely with the numbers actually observed. The local work load for the teachers however is greater than this prediction, because we accept a number of cases from outside the city, where facilities for the profoundly deaf child are not available. At present there are 15 pre-school children receiving attention: 11 of these are from the city, and 4 from further afield. At the Maud Maxfield School for the Deaf there are at present 91 pupils, and in the Partially Hearing Units, 44.

So far as detection and diagnosis of deafness is concerned, the Audiology clinic is the end of the line. So far as management is concerned it is the beginning.

The main function of the otologist in this respect is the prescription of hearing aids. All severe and most of the milder bilateral cases will need this assistance. The type of help given to children to enable them to get the fullest

value from their hearing aid depends on their age and the severity of their deafness. The profoundly deaf child will receive an aid at an early age, and the parents will be given advice on its use from the pre-school teacher of the deaf. The older child who develops deafness will receive his help from the peripatetic teachers of the deaf.

The peripatetic service is well established in Sheffield. It provides a feed-back of most valuable information to the Audiology clinic. In the first term of 1970, 96 children received a total of 486 visits. Many of the children have severe catarrhal problems, but some also have mild or moderate sensorineural loss. These cases are regularly reviewed by the otologist, and it is most useful when they are accompanied by a report containing an informed opinion on the child's performance, and the effects of his hearing loss on this performance. Advice from such a source could be that a child is coping well without an aid, or that he does need some form of amplification, or that the the amplification provided is less than ideal. To act on such advice is more likely to help the child than an arbitrary decision by the otologist in the clinic. The peripatetic teachers of course give extra tuition where it is needed, and can also give most helpful advice to the child's ordinary teacher.

For most cases of severe deafness the choice of education lies between a Partially Hearing Unit, and the Maud Maxfield School for the Deaf. The chief factor in deciding which of these is most suitable is the quality of the child's speech. Many children move to the Partially Hearing Unit from the School for the Deaf after a few years. These moves may be tried experimentally and reversed should the experiment fail.

The useful role of the otologist in the schools is limited. Personally however I have always enjoyed visiting the school, and aim to do this each term. It is an opportunity for the Head and his staff to discuss problems of common concern. Any child with a specific otological problem is examined. Through these visits I have learned first-hand of the problems which face the deaf child and the equally great problems which face his parents. With this experience I have found it much easier to counsel the parents in the earlier stages of their problem in a manner which I hope helps to sustain them until they are able to accept fully the fact of the handicap and all that it entails.

We have in Sheffield recently experienced the introduction of comprehensive education. Such a major change of policy was bound to have wide repercussions and education for the deaf did not go untouched. The Partially Hearing Units had to be redistributed and resited to cover the whole range of school ages under the new system.

Major changes are now planned in the Health Services and a completely new administrative system is proposed which may see the end of the existing Regional Hospital Boards, Hospital Management Committees, Executive Councils and Local Health Authorities. It is not easy to see what repercussions such drastic changes will have at the level of the School Health Service, with its medical and nursing officers from whom the Audiology Department is largely drawn. Clearly some sort of audiology service will continue to be provided, and presumably the same people who staff the present service will continue, perhaps under new management.

The chief virtue of the present service is that it is comprehensive; there is harmony between the medical and educational disciplines, and the deaf child may pass from one to the other as necessary, in either direction, with the minimum of difficulty or delay. The service must change and adapt itself to new situations; and it must change to take advantage of progress in the science of Audiology. It is hoped, however, that any change will not diminish the integrity of the present service, which has provided, and is providing the deaf children of this City with such fine facilities for overcoming their disability.

UNITS FOR PARTIALLY SIGHTED CHILDREN

'The eye is not satisfied with seeing'
Ecclesiastes 1 : 8

In 1905, Dr. James Kerr, School Medical Officer for London, reported that some school children were neither blind nor sighted and, in 1907, special instruction was given to partially sighted pupils in London and Nottingham.

The first special class was established in Camberwell in 1908, and from then on others were established in various parts of the country. Some of these classes became schools as more and more partially sighted children were found. The 'myope' school had arrived!

Some authorities formed departments in other special schools; many partially sighted pupils were educated in schools for the blind; others found themselves in schools for the delicate, and so on. In the mid-thirties, some of the children with myopia were transferred by some authorities to normal schools because it was thought that any advantage secured by using special educational methods in schools was soon lost on leaving.

The 1944 Education Act stated, in effect, that the partially sighted, as with all other handicapped children, should be given special educational treatment according to their needs. Most of them were already receiving suitable education, but a few were still being educated as blind, being forced to use tactile methods and braille when their sight was efficient enough to use sighted methods.

A few authorities have tried to integrate partially sighted pupils with normal pupils in a normal school. Units of partially sighted have been formed and various degrees of integration have been tried, but most of those units have been closed and the pupils transferred to special schools for the partially sighted.

In Sheffield, there are two Units for Partially Sighted Children in normal schools, and it has been found that the children in those Units are able to integrate with their fellow pupils and that this has the following advantages for them rather than their being in special schools:—

1. The partially sighted are able to mix with sighted people as much as possible.
2. The pupils come under the influence of a wider range of teachers and sometimes this can act as a stimulus.
3. Specialist subject teachers are readily available in the normal schools.
4. There is accommodation in the Unit where a specialist teacher of the partially sighted can resolve any difficulties.
5. If the child is categorised as partially sighted for a short time then this system assists his return to normal classes.

6. Lenses have been developed which enable some partially sighted pupils to take their places in normal classes.

7. Whole class teaching is becoming less popular and the teaching of small groups is increasing and this facilitates integration.

Sheffield opened the Maud Maxfield Myope School in August, 1913. It was in a schoolroom of the Lancasterian Infants School and there were 13 pupils, 10 girls and 3 boys. This was closed two years later and the pupils were transferred to the Valley Road Methodist Chapel, where 2 classes were formed. In August, 1923, the Maud Maxfield Myope School was re-opened at East Hill with 94 pupils aged from six to sixteen in four classes. The Head Teacher took 20 pupils and his three assistants took 25 each. By 1934, the school had 120 pupils and in 1937 it was transferred to Arbourthorne Council School.

During the mid thirties, due to new ophthalmological thinking, the high myopes were gradually transferred to ordinary schools and in June 1944 the partially sighted were moved once more, this time to Bents Green Open Air School for Delicate Children into a prefabricated building which housed two classes of up to 15 pupils each.

At Easter 1965, the partially sighted children were moved from Bents Green and formed into two units; the Infant and Junior Unit went to Stradbroke Primary School and the Senior Unit to Brook Secondary Modern School (now Brook Comprehensive School), and it was decided that the partially sighted must integrate with the normally sighted whenever possible.

Pupils in the Junior and Infant Unit are integrated in corporate activities of the school and with children of their appropriate age for music, drama, P.E., dancing, games and swimming. Individual partially sighted pupils are integrated in other classes for various lessons, according to their age, aptitude and ability, and children of nursery and infant age are integrated into the Infant School classes for activity periods each day.

In the Senior Unit a recent survey showed that all partially sighted pupils who had only the one handicap of sight have been integrated fully with their peers; the pupils who do not integrate fully have at least one other handicap and some have four or five handicaps. External examinations such as C.S.E. and G.C.E. are taken whenever pupils reach the required standard. One ex-pupil has this year been offered a place at Yale University and another who was thought to be E.S.N. at the age of 5, and who left when the partially sighted were at Bents Green, is now lecturing after gaining a degree at Cambridge.

SCHOOL DENTAL SERVICE

'Thais has black, Læcania white teeth; what is the reason
Thais has her own, Læcania bought her's'
'Epigrams' Martial

A continuous effort has been made in Sheffield during the last thirty years to provide dental care for handicapped children in schools and sub-normal adults in training centres. The service has been limited because of the necessity of working on a shoestring in terms of accommodation and staff, but those in daily contact with children in special schools acknowledge that there have been handsome rewards in the improved dental health and well-being of the children. A very progressive step forward might have been made some fifteen years ago when a request was made to have a well equipped and suitably designed mobile clinic provided to visit each special school in turn. The idea of a mobile clinic was not well thought of, but perhaps the request was not such a bad one as the Inner London Council has quite recently bought a mobile clinic for this purpose.

The special schools were widely separated at Mayfield, Whiteley Wood, Bents Green, Manchester Road, Handsworth, Highfield, Wadsley Bridge and Arbourthorne. From the first, four schools were treated by means of a mobile dental drill, an old students' cabinet of instruments and various odd dental chairs. One of these, a funny looking wooden affair dating back to the early 1900's, is still in situ at Tapton Mount School where the barber makes more convenient use of it than the school dentist. Children from schools other than these four visited the Central Clinic, with one exception; Highfield School was and is still attached to the Heeley Clinic. That parents appreciate our providing treatment on the school premises can be judged from the experience gained at Arbourthorne School. The acceptance rate for treatment was as low as 30% when parents were expected to take children, mostly handicapped by immobility, to a clinic. The second year after treatment was provided on the school premises, 91% of parents accepted the offer of treatment. It is interesting to learn from the booklet produced by the New Zealand Government commemorating the Golden Jubilee of its School Dental Service that all dental clinics in that country are required to be placed on school premises. The New Zealand service has been a model for other countries for many years and in fact a commission was sent there some years ago by the Department of Education to study it.

In Sheffield, the position now is that normal children and adults have no difficulty in obtaining treatment but for those who are handicapped either mentally or physically, the position is quite different. Their treatment, to be successful, needs unusual knowledge and experience which general dental service practitioners have not had reason to obtain. Again the time

consumed in performing quite a simple operation such as the filling of a tooth in an athetoid child is quite out of proportion to the fee obtained for such treatment at the flat rate of itemised fees to which the private practitioner is subject. There are other difficulties which deter the handicapped patient from obtaining adequate dental care of which the lack of mobility is the most important for some, and this alone prevents many parents from seeking treatment except under the urgent driving force of pain.

Whereas 1,134 children attended special schools in 1952 the number has now grown to 2,035. When Chantrey School was built a small surgery was included in the school premises and this now provides treatment for the pupils of Chantrey, Oakes Park and Mossbrook Schools. It is said to be the first special school in the country to have its own dental surgery. The dental officer in this case becomes accepted as one of the school staff, as a friend of the children who will then encourage each other to have treatment. The benefits of this are very obvious.

In the same way it is said that the Public Health Department was the first to provide a Junior Training Centre with its own dental surgery. The equipment was limited to that sufficient for the extraction of teeth. But now the Norfolk Park and Talbot Training Centres have become schools and parents are becoming more aware of the need for conservative treatment and regular scaling and cleaning of teeth. (The teeth of these children must be preserved and kept attractive if they are to be welcome in society). The present surgery is small, used part-time as an office, its share of daylight is inadequate and it should be properly equipped. Under the present working conditions, no more than emergency treatment can be given. A purpose built dental surgery with waiting and recovery room accommodation is needed with equipment adequate enough to provide comprehensive treatment for what is admittedly a very difficult group of patients to treat. If this were coupled with the provision of accommodation for medical staff a very useful centre could result. Some 350 adults at these centres continue to attend the Norfolk Park surgery for the extraction of teeth but much more could be done for them. A surgery here would be convenient for the 222 boys and girls at the East Hill Senior and Junior Schools and considerably more suitable than the Central Clinic. It is forecast that the numbers in attendance at these schools and at the training centres will grow. They could very well occupy the greater part of the time of a dental officer committed to this work, and the benefit to them is unquestionable.

The degree to which a community is civilised and aware of the social needs of its underprivileged and handicapped members can be measured by the extent to which it relieves their difficulties and hardships. Dental

health is not a luxury and those who cannot actively seek dental care are not to be ignored. The dental profession is aware that the majority of handicapped people, both old and young are not receiving the dental attention they need. A national study group recently stressed the urgent need to increase the number of dentists who have had special training in dentistry for the handicapped. No provision is made for this in the regulations governing the training of graduates in dentistry made by the General Dental Council and the profession recognises that the service provided under the General Dental Service Regulations to handicapped persons is inadequate. All the various surveys and information published in recent years reveal inadequate services, or services which fail to deal with the provision of dental health. The responsibility for the dental treatment of handicapped persons after 1974 has not yet been allocated but given adequate accommodation and trained staff it may happen that the most competent body for this would be the Local Authority and its Education and Social Services Committees. At the present time the local authority has some responsibility but the majority of the 1,129,000 persons who are reported to be sufficiently handicapped to need supporting help are elderly and no special service for dental treatment is available to them. Now that the National Health Service has settled down to a degree which allows school children to obtain all the dental care they need from the general practitioner, it may come about that the treatment potential of the local authority services is increasingly directed towards those who are handicapped and now emerging as a priority group.

PROVISION FOR DISTURBED CHILDREN
THE CHILD GUIDANCE CENTRE

'I will try to extricate him from his thoughts'
Eugene Millikin

The Sheffield Child Guidance Centre, at present situated at 9 Newbould Lane, is the base of the Child Guidance and School Psychological Services. Branch clinics are also held at Hillsborough and at Birley, and the School Psychological Service, as its name implies, carries out most of its operations within schools throughout the City.

Children are referred to the Child Guidance Centre by their schools, family doctors, the health and social services, and by their parents. Some will have been seen initially at their schools and form that proportion of the cases investigated by the School Psychological Service where it is felt that more extensive examination and treatment should be conducted by the child guidance team. In the case of these children, and those referred directly for clinical treatment, psychometric assessments of intelligence and attainments, and of motivational, emotional and other personality factors, interviews with parents and teachers etc. are supplemented by clinical observations and treatment over a prolonged period, frequently involving the regular counselling of at least one parent as well as the child himself. The child psychiatrists conduct most of the playtherapy and psychotherapy with the children, through establishing a very close personal relationship into which the child projects his phantasies and releases his emotions. Some of the treatment is carried out by educational psychologists who will also be concerned that the re-educative and insight gaining features of treatment are communicated to the child's educational setting, so as to provide his teachers with techniques for behaviour modification in the classroom. Both psychologists and psychiatrists are also concerned to establish patterns of readjustment in families, since children's problems so often relate to their management at home, although the major contribution to this aspect of the treatment is usually that of the psychiatric social worker, whose skills in interpreting social histories and carrying out intensive family case-work are here brought into play. It would, however, be an oversimplification to suggest that the psychiatrist is the main agent in the clinical treatment of the child, with the psychologist concentrating (apart from psychodiagnostic work) on the school situation, and the social worker on the home, since all these roles interact and each frequently needs to be assumed by members of the team from all the three disciplines.

The Child Guidance Centre is mainly concerned with children's behaviour and nervous disorders. These include abnormal aggression and timidity, antisocial behaviour such as stealing, habit problems such as enuresis, soiling and stammering, tics, hysterical and psychosomatic dis-

orders, sleep disturbances, learning problems associated with chronic anxiety, truancy, school phobias, wandering and, at the extreme, the very rare occurrence of psychotic states or problems due to organic disorder of the nervous system or metabolism.

The Child Guidance Service is a link in the chain of child specialists which frequently includes other social workers, paediatricians, child neurologists and child psychiatrists in the Health Service and, of course, teachers in special schools, remedial teachers and school counsellors. The other child services are both sources of referral and also resources which the Child Guidance Service frequently calls upon. The Child Guidance team pools its knowledge and expertise through its own regular case conferences, and both contributes to, and gains from, conferences with teachers and other workers at which collective decisions are frequently made.

EDUCATIONAL THERAPY FOR MALADJUSTED CHILDREN— BROAD ELMS SCHOOL

'I have had more trouble with myself than any other person I know'
Dwight L. Moody

Broad Elms School, Sheffield's first day school for maladjusted children, opened with sixteen children in September, 1969 in temporary accommodation, before moving to purpose-built premises in January, 1970. Admissions have continued at a controlled rate so that the number of pupils is now 32. Ages span the normal school range from 5 to 16 and, as is usually the pattern in schools of this type, there are considerably more boys than girls, the ratio at present being eight to one.

The school is organised as three units of two classes each. These consist of infant and younger junior children in the first, children of middle school age in the second, and secondary age pupils in the third. So far this system of age grouping has been considered to be more satisfactory than the 'family grouping' system used in some schools for the maladjusted.

The aims of the school are centred on an attempt to meet the disturbed child's unsatisfied needs for security, affection, and the development of sound work and play habits. Reliance is placed on a framework of routine, and control through reasonable rules. Within such a framework, the pupil is given security, yet is free to learn lessons in personal responsibility and self-control as well as independence. Each child is offered reassurance and confidence through being liked for himself and through membership of a secure group to which he can contribute.

In order for satisfactory personal relationships to develop, it is necessary for pupils to be in small groups of normally not more than eight to one teacher and often fewer, with ancillary help where necessary. Classrooms are so designed that in each there is a 'quiet' area with books, easy chairs and television, a practical work area where such activities as painting, modelling and cookery can be carried out, and an area for basic subject work, with easily moved chairs, tables and lockers. It is possible to use any of these areas throughout the day, as each pupil's particular needs and interests are studied and followed. Toilets and cloakrooms are an integral part of each classroom block. A forum enables such activities as physical education and drama to be carried out with specialised apparatus. The school has its own kitchen, and family dining takes place in an area central to all the classrooms.

The grounds, at present only partly developed, are intended to offer the additional facilities of an adventure playground and jungle gymnasium, a pet keeping area, garage/workshop and camping site. The possibility of a self-help scheme to build a small learner swimming pool is also being considered.

It was early found advantageous for small groups to spend some time each week outdoors. Educational visits, walks and expeditions have been popular at all levels, and such activities with older pupils have been developed to include camping, youth hostelling and adventure pursuits such as rock climbing, canoeing and horse riding. A successful start has been made with the Duke of Edinburgh's Award Scheme. Swimming has been universally popular and has proved to be most valuable therapy as well as recreation. Football fixtures with other schools now take place regularly.

Initial difficulties in running the school arose from the fact that a high proportion of the children referred were in a group that could be considered to be acting out their emotional disturbance in an aggressive and hostile manner. A number had already been excluded from other schools. As might be expected, the pupils of secondary age proved most difficult, and these have generally responded more slowly to treatment. It must be recognised that these cases should be referred as early as possible and that even then a school for the maladjusted cannot be expected to deal successfully with more than a proportion of such cases. The importance of achieving a balance of types of emotional handiccap cannot be overstated. At Broad Elms School it has been possible to vary admissions to include other types of emotional handicap and so create a better balance through which an overall therapy can take place. Selection such as this, coupled with continuing medical and psychiatric oversight, has necessitated close co-operation between the school, the Senior School Medical Officer and the Child Guidance Centre. Members of the Centre staff (Consultant Psychiatrists, Clinical and Educational Psychologists), visit the school regularly for case work with children and case conferences with school staff. A Nursing Sister maintains contact with parents and a Parent/Teacher Association has been formed.

In terms of progress since the school's opening, it is possible to say that in some cases, particularly among the younger children, there has been a marked reduction in aggressive and other anti-social tendencies. In general the children are relating better to staff and to each other and there is a growing corporate awareness. It was hoped initially to create the atmosphere of a 'family' school and to some extent at least this has been achieved.

SHIRLE HILL HOSPITAL SCHOOL

'Clara's blue eyes were as innocent as if they had entered their sockets a half-hour ago'
'Gaily, Gaily' Ben Hecht

Shirle Hill Hospital School was opened in January, 1970. The School is in a new specially designed building provided by the Sheffield Regional Hospital Board. It is situated in pleasant surroundings adjacent to, but separate from, a large house which has been converted to provide residential accommodation for twenty psychiatrically disturbed children aged 3—11+ years. Sixteen of these children are in-patients. The remaining four places are for children who have been discharged as in-patients, but attend on a day basis so that treatment may continue.

This is a joint venture. The school building is provided and maintained by the Sheffield Regional Hospital Board, and the Sheffield Local Education Authority is responsible for all teaching appointments and the provision of equipment and furniture. The Unit caters for short stay observation and treatment but lack of other facilities in the area necessitates the inclusion of some long stay children. The children are drawn from a wide catchment area which serves a population of approximately 1,600,000.

The school consists of two large attractive classrooms each with toilet facilities, work area complete with sink, and work benches. Both classrooms have integral store rooms but the function of one of these has been changed. Now it is a carpeted quiet area which has proved invaluable as a retreat for those children who have found group situations too demanding. Furniture has been chosen for multi-purpose use. Cupboards, trolleys and display easels are on castors, and tables and chairs are easily stacked so that the classroom layout can be quickly changed to cater for different activities as they arise.

There is a high ratio of staff to children. The staff includes a Consultant Children's Psychiatrist, Senior Registrar, Senior Clinical Psychologist, General Practitioner, Medical Social Worker, Sister in Charge and nursing staff, as well as teaching staff. These make up a comprehensive team, all of whom bring particular skills and expertise to bear on each child's problems. Close communication with and confidence in one another is absolutely essential for the staff. Understanding at all levels is encouraged through meetings both formal and informal. There is a short daily conference between Sister in Charge and the Head Teacher, a weekly conference with all junior nursing staff led by the Senior Registrar, a weekly conference attended by the Consultant Psychiatrist, Social worker, Sister in Charge and the Head Teacher and a weekly case conference at which special cases are discussed in depth. Medical, nursing and teaching staff attend and a

report of the proceedings is prepared by the clerical assistant. There are two other meetings each week for teaching staff to discuss work programmes and educational matters. There are many other opportunities for discussions particularly when medical staff are in the school.

At the request of the Sheffield Regional Hospital Board the school year lasts 46 weeks. Last year the Unit was closed for one week at Christmas, one week at Easter, another week at Whitsuntide and three weeks in August. There are no half term breaks but the teaching staff take the leave due to them at other times during the year.

Individual therapy, group therapy and education are provided for each child according to his own needs, with the result that groups are variable and a great deal of individual tuition is given. Frequent discussions between the Senior Clinical Psychologist and teaching staff pin point areas of learning difficulty peculiar to individual children. Special attention is paid to detailed programming of school work in order that each child will have the opportunity to gain experience and the motivation necessary to help him cope with his difficulties.

Emphasis is laid on sensory experiences and language. These children have often failed to enjoy school for their preoccupation with their own personal problems has reacted against learning. All the children benefit from these experiences whatever their problems. They may be non-communicators (25 % of the children are designated autistic), elective mutes, withdrawn, linguistically deprived or children who exhibit other behaviour and habit disorders.

The provision by the Sheffield Regional Hospital Board of a pottery kiln has meant that pottery has been added to the many and varied Art and Craft activities which are an essential side of the work done by the children.

On the day of admission, the parents accompany each child to the unit and a visit to the school is an accepted part of the procedure. This provides an opportunity for the parents to discuss the child in relation to school, and for the Head Teacher to reassure parents about the role of the school while the child is an inpatient. Throughout the child's stay the parents are encouraged to keep in touch with the school.

As soon as a child is admitted to Shirle Hill, contact is established with the Head Teacher of his previous school. This contact is maintained throughout his stay and regularly after his return to his previous school or with the new unit if the child is transferred elsewhere. Co-operation and help are always forthcoming. All Head Teachers are invited to visit the school during the child's stay. Class teachers, particularly at the crucial transition

stage prior to the child's discharge, are afforded an opportunity to spend at least one session in the classroom at Shirle Hill. These contacts are most valuable and very encouraging for the child's rehabilitation after he leaves Shirle Hill.

THE HOSPITAL SCHOOLS

'The basic test of freedom is perhaps less in what we are free to do than in what we are free not to do'
Eric Hoffer

The admission of children to hospitals causes considerable emotional stress both to the children and to their parents. In young children, what must appear to them to be rejection by their parents, is usually followed by periods of crying which may go on for some days, and then give way to a stage of despair, during which they sometimes appear to reject their parents.

Unrestricted visiting by parents alleviates these difficulties with some children, but for many this is not possible and the emotional stress arising from the changes in their life and routine may have a serious and long-term effect on them.

Teachers in hospitals help children in their unusual and often physically difficult situations by providing them with suitable activities and, at the same time, enable them to keep up to date with their school work ready for their eventual return to their own schools.

Sixty years ago, teachers were appointed to work in the Lord Mayor Treloar Cripples Hospital and Colleges and, in 1912, it was recognised by the Board of Education as the first hospital school.

Sheffield was not far behind in that development for in the 1918 Report of the Medical Superintendent of King Edward VII Hospital we are told that:—

"Children who are residents for long periods in an Institution need kind but firm handling, and should be given occupations suited to their limitations, or they will lose that mental distraction and activity which is such a powerful aid to cure. And patients who live in Hospital for several years of their school life will be naturally very backward unless some means be taken to educate them. An arrangement was therefore made with Sheffield Education Committee, by which it was agreed to provide the requisite number of teachers. The Hospital is recognised as a Residential School by the Board of Education. All the usual subjects are taught; special attention being given to handwork, reciting, singing and reading. The children receive about 4 hours' instruction daily. The children thoroughly enjoy their school hours, and the occupation undoubtedly keeps them happy, and is an important adjunct to the medical treatment. On March 31st, 1918, there were 96 children on the Roll".

Since that time, the King Edward VII Hospital School has become responsible for the education of children in the Northern General and Lodge Moor Hospitals, and a separate hospital school at the Sheffield

Children's Hospital provides for the education of patients in that hospital and in the Ryegate, Thornbury and Fulwood Annexes as well as the children and young people in the St. Joseph's Hospital.

In addition, educational facilities are provided for children in other hospitals in the City when their own schools make arrangements with the teacher responsible for the Home Tuition Service at Oakes Park School, Matthews Lane.

When children are likely to be in hospital for some little time, assistance and the loan of appropriate books from their own schools are most helpful, especially with C.S.E. and G.C.E. work.

Where children are likely to be away from school for a further three or more weeks after they are discharged from hospital, the Head of the particular hospital school arranges for teachers from the Home Tuition Service to assist with their education throughout that period.

THE HOME TUITION SERVICE

'It is impossible to enjoy idling thoroughly unless one has plenty of work to do'
'On being idle' Jerome K. Jerome

During the second World War, it was not possible for some of the children who had attended the Unit for Crippled Children at Nether Green School to continue to do so and arrangements were made for them to be taught in their own homes. This was the beginning of the Home Tuition Service, which was soon extended to other children who, for various reasons, were unable to attend school. The service was provided from the Arbourthorne North Physically Handicapped School and, in 1949, it was extended by the provision of similar facilities from the Mayfield Physically Handicapped School.

When those two schools combined in 1962 to form Oakes Park School for Physically Handicapped Children, the Home Tuition Service was attached to that new school, where it still remains. Most of the teachers engaged in the service are employed on a part-time basis, but in 1969 a full-time teacher, Mrs. N. Cowley, was appointed to the staff of Oakes Park School with special responsibility for the Home Tuition Service.

The children are taught in their own homes and receive two or more half days' education per week from one of the visiting teachers. The numbers of children being educated in this way vary considerably since some are able to return to their schools within just a few weeks, whereas others may never be able to do so. These children fall into four main groups:—

(*a*) Very severely handicapped children who could not cope with the school routine in a normal school or even in a day school for physically handicapped children.

(*b*) Children who are prevented, owing to accident or illness, from attending their own schools for three weeks or more.

(*c*) Children who have been in hospital and need short term help before returning to their own schools or who are awaiting a further period in hospital.

(*d*) Emotionally disturbed children who are unable to attend their normal schools.

In addition to teaching children in their own homes, the Home Tuition Service also provides for children who are in hospitals such as the Royal Hospital, Royal Infirmary and Whiteley Wood Clinic where there is not a hospital school. Their own schools must send information about them to the teacher responsible for the Home Tuition Service at Oakes Park School.

Wherever possible, teachers in the Home Tuition Service establish close links with their pupils' own schools and try to continue their work along the same lines. Their children have then the advantage of being taught on an individual basis, but this cannot make up for the isolation which arises because they are not able to be with their peers and enjoy the company and the stimulation of the classroom.

In suitable cases, teachers try to reduce this isolation by taking children on visits to museums, gardens, shops and libraries and, when this is not possible, Youth Action and other voluntary organisations are asked to help by visiting the children in their own homes.

SCHOOL NURSING SERVICE

'Women are wiser than men because they know less and understand more'
'The Crock of Gold' James Stephens

The School Health Service has had the support of school nursing sisters since its inception in 1908. At present there are 35 school nurses and 15 nursing assistants, apart from the four residential nurses in special schools. School nurses must have a minimum qualification of State Registration, though a Health Visitor's Certificate is very desirable since much of the work is similar to the health visitor's and this element seems likely to increase. The school nurses attend school clinics, visit schools, and undertake an increasing number of home visits.

School clinics were set up to provide a general service which is now really the General Practitioners' work and most of the work now done in this respect should be in support to the family doctor.

Specialist clinics are still run for although 23 years have passed since the inception of the National Health Service, the Regional Hospital Board have not yet made provision for these clinics to be undertaken in hospital premises. Apart from the Audiology clinic which is part of a closely integrated service for deaf children, there seems to be no particular advantage in other special clinics being provided for school children.

The replacement of old schools means that the use of clinic premises for periodic health inspections has now almost ended, and the movement of population has also detracted from the value of existing clinics. Work in schools is increasing. In secondary schools particularly, the increased size of the schools is highlighting the amount of teacher time that is spent in dealing with cases of accident and sudden illness. Various methods of attempting to deal with this problem have been adopted, but all schools seem to welcome help. Even in the largest school however this is nothing like a full time job. The problem is that the load and incidence of work is unpredictable, and causes disruption of other duties.

Increased interest in health education is meaning more and more call on the school nurses, sometimes to lecture but more often to discuss problems with the teaching staff.

The evaluation of minor physical handicaps and the attempts to help the physically handicapped children to integrate successfully with the normal school community also require good liaison and co-operation. While the class teacher is responsible for helping in this work or integration or referral of problems often recognisable only in the classroom, the school nurse if a frequent visitor may well be the best co-ordinating link.

In addition to these new and developing fields of work within schools, it is likely that many of the traditional activities will continue. Some form of medical screening is essential at school entrance though the present system may be modified. Hearing and vision screening will continue and may well be extended.

The school nurses also undertake hygiene inspections and this need will continue for the foreseeable future in certain areas. Infectious diseases are always likely to disrupt community groups and the school is no exception. The school nurse fullfils a very useful function in investigating and limiting these outbreaks, and co-ordinating with the public health inspector.

From time to time the nurses also carry out certain more general enquiries, ranging from a simple survey of children who have hearing aids to see if they require assistance and training in their use or whether the present system is adequate, to the elaborate National Survey by the National Bureau of Co-operation in Child Care following up the 1958 Cohort.

Although most of the nurses' work is carried out on school premises, home visits are nonetheless an essential part of her work. As schools become increasingly aware of the need for contact and liaison with parents and home, the need for home visiting has increased. Much of this is done in co-ordination with the Education Welfare Officer who may appreciate advice in health matters. Transfer of the Education Welfare Service to a Social Service Department may well require the school nurse to provide even more co-ordination in these circumstances.

Nursing assistants were first appointed in 1943, because of the shortage of nurses and the opening of nursery classes. These assistants have carried out such duties as weighing and measuring, cleansing and other routine clinic work. Selective weighing and measuring, and the reduction of the work in cleansing and hygiene and of clinic work generally, have reduced the work they have been able to do.

The changing calls made on the School Nursing Service led to the introduction two years ago of three experimental schemes. At Myers Grove, for example, the school medical officer had already built up close relationships with the school and it was, therefore, easy to use the school as a base to provide care for the infant and junior feeder schools.

In the Greenhill area a school nurse and an assistant were based at Rowlinson School with one always being available either in Rowlinson or Jordanthorpe schools, while a regular scheme of visiting all the feeder schools was undertaken. The nursing assistant chosen had a first aid qualification. It appeared after a short time however that she herself did

not feel this to be adequate and further training is necessary if nursing assistants are to be employed in this way. This and the considerable increase in work meant that another nurse had to be introduced and, while the Greenhill clinic attendance figures dropped slightly from 1,000 to 800, the nurses were seeing in addition some 2,400 children in school. There has been more regular visiting of the feeder schools and they have had the advantage of knowing that a nurse is always available. The effectiveness of our scheme was greatly increased by the nursing sister's readiness to use her own car for journeys between schools.

The third scheme at Hurlfield was agreed after consultation with the Head Teacher who together with the school doctor was very keen that clinic sessions should be held in the school. This has in fact provided more evidence of the relative advantages of doctors working in clinics or schools but further enquiries into this problem are needed.

During the last few years the School Nursing Service has been grappling with the problem of how to meet the pressing and varied problems of large secondary schools, while at the same time providing an adequate service for often small primary schools. The recent decision to appoint a Director of Nursing Services for the Health and School Health Services is intended to promote a solution to this as well as other problems.

RESEARCH AND DEVELOPMENT

'Even when one achieves nothing, one smells the odour of truth in hiding'
Jean Rostand

To improve our services and develop our understanding we need to try out different methods and investigate previously untackled problems. School Health is no more free of that duty than other sections of the service, and is indeed a field where much fruitful work can be done.

Compulsory education means that knowledge of virtually the whole population between the ages of 5 and 16 can be obtained. However, here lies a snag. The very fact that the law requires a parent to submit a child for medical examination confers a responsibility on the Education Committee and School Health Service to ensure that the information obtained or obtainable should not be abused, and this is perhaps the first and most important consideration when surveys and research are proposed.

Then it is important that the work can be undertaken at reasonable cost, and a careful comparison be made of costs and the anticipated benefits. It may well be possible to improve our service at the same time as collecting information for others. Thus, when in 1969 the Department of Education and Science asked us for the number of physically handicapped children in ordinary schools, we had no ready means of supplying this information. The resulting survey showed the high figure of 545 children (there were at the time 130 physically handicapped in special schools), and this formed the basis for a register which is available to the medical and nursing staff visiting schools. It is noted that in Scandinavian countries, considerable experience has been gained in educating physically handicapped children in normal schools.

From this register we have been able to help in providing figures for a number of national surveys. One such survey was the result of national concern whether the medical cover of haemophiliacs in school was adequate, whether education was much interrupted by episodes, and whether special provision was necessary. Co-operation with the hospital paediatricians resulted in the discovery of six children with this complaint and, with the possible exception of one child who is still under school age, their existing placement did not seem to present undue risks.

Regionally, we have co-operated in providing figures to indicate specific needs in special education. Surveys have been carried out by the Yorkshire Association of Education Officers on the needs of deaf/blind children and of autistic children. With this last, the numbers of autistic children in Sheffield were considerably smaller than might be expected. As this Authority could well be criticized for failing to identify such children,

the position has been looked at again. So far no explanation has been found and it may well be that the causes of the condition will need to be determined before an explanation is forthcoming.

A number of small surveys have been done within the department. A survey of children with hearing aids in all schools was undertaken in order that these children might be helped with their aids if necessary, and the development of our peripatetic service was based on evidence from this survey. A survey from the School Health Service records of those children who attended Fairthorn indicated the number of social problems that needed to be met, and highlighted the importance of these children having educational help while resident. One medical officer did a survey of all the cases of verrucae he saw. He was, unfortunately, unable to show anything conclusive regarding the mode of spread.

Though much can be collected from our existing records, it may well be necessary to examine the children and visit their homes in order to obtain information. This collecting of further information qualifies as research and produces additional problems. First, it is rarely possible to cover more than a small proportion of the population, and it is therefore necessary to ensure that the sample is representative of the population. An exception to this was the nutriton survey that the Department of Health and Social Security undertook early in the year. Sheffield was chosen as one of four areas, but the schools selected were not representative of the City as a whole but rather picked out as those areas where there might be nutritional lack. Schools were selected where the population was stable, so that comparable children can be examined in a further survey in two or three year's time.

Perhaps the most important research that we have been able to play a part in is the follow-up by the National Children's Bureau of 11,000 children born between the 3rd and 9th March, 1958. Every child born in England during that week has been included in the survey, which included 158 Sheffield children at the 11 year old follow-up. For the first time it has become possible to follow up the development of children. Detailed information was obtained on all the children at the time of birth, including children who had difficult births or whose parents had other problems. By following up these children at 5, 7 and 11 years, the development of such children compared with an equivalent sample of the normal population will certainly provide extremely valuable information on the importance of illness in infancy and the management of pregnancy and childhood, and may well lead to earlier identification or even prevent altogether some of the many handicaps children suffer educationally and socially. The 11 year old follow-up contained detailed questionnaires on

educational progress and social environment, as well as a detailed medical examination. Perhaps the biggest problem is processing the wealth of information obtained, and there are many aspects to be studied. For example, one of the recent results published shows the very considerable disadvantage still of being born illegitimate.

The Authority also provided accommodation and other facilities for a study of gifted children carried out by the National Children's Bureau.

In order to facilitate study of periodic health inspections, Dr. J. E. Lunn was appointed as a School Medical Officer in an honorary capacity. His studies, published in 1968, showed how much is already known about most children's physical handicaps by the time they reach school and how little additional information can be obtained by physical examination. It is clear from this survey how important it is for all the information available to be at the disposal of the School Medical Officer so that problems can be anticipated, and difficulties be discussed with teaching staff; in this the School Medical Officer acts as co-ordinater rather than initiating medical treatment and care.

Help has been given to a number of individual research workers. Studies on hand-eye co-ordination, related measurements of spina bifida children, verbal behaviour of hydrocephalic children, small statured females, XYY chromosomes, are some of the subjects investigated. A survey by Dr. Eid of the Department of Child Health, using the heights and weights measurements made at school showed that, where there was an excessive weight gain in the first 6 months, the child was likely to be obese at 6 to 8 years. This survey would suggest that in some cases at any rate, the problem needs to be tackled in infancy. Is the habit of overeating started early?

One or two surveys have, of course, had to be abandoned. A proposed national survey of one-parent families and their problems was abandoned through administrative and financial difficulties, though it might have produced valuable information. A survey on smoking in pregnancy, which had been shown by the late Professor Scott Russell to lower the average birth-weight, was proposed to see if there was intellectual impairment later. It became clear however, that the detailed examination of sufficient children to demonstrate any significant findings would be beyond the capacity of the department.

A request for information on the father's employment by a research worker on children placed on probation in 1966 had to be refused. Though the father's occupation appears on the medical records, the information is obtained at school entrance and, apart from change of job, it is surprising

how often neither child nor mother know much about the father's job. The work involved in collecting more accurate information would have been difficult to justify.

Further studies are proposed or under way. The decline of attendances at minor ailments clinics, and the increasing need for medical and nursing services in school needs investigation. A preliminary study in July, 1971, needs to be followed up in winter to see if the pattern alters.

A further survey of heights and weights is proposed. It is hoped to calculate standard deviations which will give an indication of how far removed a measurement can be from the average and yet be considered within normal limits. A pilot study suggests that the spread of measurements can vary considerably at different age groups.

The number of children with persistent urinary infections is to be investigated in 5 year old children on initial examination. The situation is, of course, explained to all parents, and may prove a valuable additional screening of this age group, though so far few children have been found with this condition.

Work which involves examination of the individual child, unless this can be closely associated with statutory obligations or work already done, is inevitably limited because of other calls on staff time. Working from School Health records on the other hand is easier and can cover more ground, but accuracy is impaired. Even the best kept records can be out of date, and it is only too easy if the information is not to hand when the record is compiled for this to be omitted. Indeed, as a by-product these surveys have a monitoring effect on the efficiency of our recordkeeping.

It is perhaps a tribute to the staff of the School Health Service that although most of the work is additional to their duties, not only have they co-operated but on occasions suggested modifications which involve more work. With evidence of this enthusiasm, it is tempting to launch out into greater projects, but this is where control must be exercised to ensure that the goals are likely to be capable of practical application if the cost in time and effort is to be justified.

STATISTICAL INFORMATION

'You should read it, though there is much that is skip-worthy'
Earl of Oxford and Asquith.

A. MEDICAL OFFICER'S INSPECTIONS

		Children	Attendances
1. Visits to Schools			
Periodic Health Inspection in School			
Total		12,521	
Entrants	8,297		
Leavers	4,224		
Special Examinations			
Total examined		1,247	
Defects found	1,185		
Required treatment	471		
Required observation	714		
Observations re-examined		4,918	
Numbers attending school clinics		7,732	10,219

2. General Condition

(Department of Education and Science classification)

Percentage unsatisfactory	Boys	0·28%
	Girls	0·10%

3. Cleanliness

(i) (*a*)	Total number of individual examinations of pupils in schools by school nurses or other authorised persons	166,738
(*b*)	Total number of individual pupils found to be infested ...	2,013
(*c*)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944) ...	3,493
(*d*)	Total number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944)	—

(ii) PERIODIC HEALTH INSPECTIONS—1971

	HEAD				BODY			
	Clean Hair	Infected Hair			Clean	Lice	Dirty	Total
		Nits	Lice	Total				
Boys ...	99·53%	0·47%	—	0·47%	99·95%	—	0·05%	0·05%
Girls ...	99·24%	0·76%	—	0·76%	99·95%	0·03%	0·02%	0·05%

4. Defects found by Periodic and Special Medical Inpections during the Year

Defect or Disease	Periodic Inspections						Special Inspections	
	Entrants		Leavers		Total			
	Requiring Treatment	Requiring Observation	Requiring Treatment	Requiring Observation	Requiring Treatment	Requiring Observation	Requiring Treatment	Requiring Observation
Skin	99	194	83	78	182	272	3,178	47
Eyes—(*a*) Vision	118	735	121	247	239	982	767	131
(*b*) Squint	113	263	10	19	123	282	23	23
(*c*) Other	10	39	5	14	15	53	136	8
Ears—(*a*) Hearing	137	227	32	22	169	249	588	117
(*b*) Otitis Media	28	142	18	34	46	176	14	18
(*c*) Other	22	88	15	11	37	99	372	25
Nose and Throat	50	573	31	81	81	654	172	73
Speech	70	382	6	16	76	398	153	37
Lymphatic Glands	—	366	1	25	1	391	—	35
Heart	3	142	5	35	8	177	13	35
Lungs	8	244	6	46	14	290	12	47
Developmental—								
(*a*) Hernia...	12	46	3	4	15	50	3	4
(*b*) Other	19	282	27	52	46	334	11	44
Orthopaedic—								
(*a*) Posture	3	15	1	16	4	31	1	6
(*b*) Feet	24	275	6	72	30	347	10	28
(*c*) Other	15	158	13	28	28	186	200	30
Nervous System—								
(*a*) Epilepsy	3	52	4	7	7	59	5	6
(*b*) Other	1	39	1	14	2	53	8	14
Psychological—								
(*a*) Development ...	10	129	1	17	11	146	108	45
(*b*) Stability	16	574	8	45	24	619	191	116
Abdomen	—	39	4	11	4	50	14	13
Other	6	44	7	54	13	98	2,114	168

B. SCHOOL NURSING SERVICE

IN THE SCHOOLS—

Attendance with school medical officers at periodic health inspection.		
Examination of children under cleanliness scheme	Boys 82,910	
	Girls 83,828	
		166,738
Examination of children for 'following up'		3,806
Examination of children for investigation of outbreak of infectious diseases		277
Attendances for breathing exercises		1,229
Number of visions tested		27,977
		200,027
Number of children referred to clinics		2,612
Number of visits to schools		18,728

IN THE CLINICS

	Eye Treatment		Ear Treatment		Minor Dressings	
	Cases	Attendances	Cases	Attendances	Cases	Attendances
TOTALS ...	235	309	439	1,016	7,665	12,182

IN COMPREHENSIVE SCHOOL MEDICAL ROOMS

	Eye Treatment		Ear Treatment		Minor Dressings	
	Cases	Attendances	Cases	Attendances	Cases	Attendances
TOTALS ...	405	494	327	739	13,666	22,906

IN THE HOMES—

Visits for 'following up'	2,036
Visits for neglect, uncleanliness, etc....	188
Visits for various purposes	1,147
	3,371

C. (i) ATTENDANCES AT CLINICS

Clinics	School Medical Officers		School Nurses	
	Cases	Attendances	Cases	Attendances
Attercliffe	676	805	1,334	1,351
Pitsmoor	524	632	282	545
Heeley	648	1,079	60	327
Central	1,583	1,962	471	1,029
Greenhill	285	416	233	505
Handsworth	294	547	275	592
Woodhouse	231	339	84	317
Shiregreen	513	584	743	1,212
Chaucer	993	1,176	959	2,369
Hackenthorpe	74	99	4	23
Manor	767	1,109	996	1,992
Wisewood	272	414	101	288
Myers Grove	448	529	1,600	1,972
Frecheville	204	278	14	85
Wybourn	220	250	915	1,218
	7,732	10,219	8,071	13,825

(ii) ATTENDANCES AT SCHOOL MEDICAL ROOMS:—

Schools	Cases	Attendances
Nursery	483	758
Special Schools ...	8,904	21,121
Others	15,514	26,257
Total	24,901	48,136

D. DENTAL INSPECTION AND TREATMENT

	Ages 5 to 9	Ages 10 to 14	Ages 15 and over	Total
i. *Attendances & Treatment*				
First visit	3,749	4,013	905	8,667
Subsequent visits	3,653	5,889	1,542	11,084
Total visits	7,402	9,902	2,447	19,751
Additional courses of treatment commenced	313	321	90	724
Fillings in permanent teeth	3,157	9,997	2,856	16,010
Fillings in deciduous teeth	4,126	342	—	4,468
Permanent teeth filled	2,587	8,572	2,583	13,742
Deciduous teeth filled	3,738	300	—	4,038
Permanent teeth extracted	634	1,917	353	2,904
Deciduous teeth extracted	5,138	1,529	—	6,667
General anaesthetics	1,685	1,021	117	2,823
Emergencies	664	401	53	1,118
Number of pupils X-rayed				342
Prophylaxis				1,853
Teeth otherwise conserved				28
Number of teeth root filled				21
Inlays				2
Crowns				23
Courses of treatment completed				7,358

ii. *Orthodontics*

Cases remaining from previous year	101
New cases commenced during year	73
Cases completed during year	58
Cases discontinued during year	16
No. of removable appliances fitted	128
No. of fixed appliances fitted	4
Pupils referred to hospital consultant	20

	Ages 5 to 9	Ages 10 to 14	Ages 15 and over	Total
iii. *Prosthetics*				
Pupils supplied with Full Upper or Full Lower (first time)	—	—	—	—
Pupils supplied with other dentures (first time)	3	21	11	35
Number of dentures supplied	3	33	22	58

iv. *Anaesthetics*

General anaesthetics administered by dental officers	1199

v. *Inspections*

(*a*)	First inspection at school. Number of pupils	31,599
(*b*)	First inspection at clinic. Number of pupils	4,477
	Number of (*a*) + (*b*) found to require treatment ...	21,415
	Number of (*a*) + (*b*) offered treatment	16,320
(*c*)	Pupils re-inspected at school or clinic	3,271
	Number of (*c*) found to require treatment	1,481

vi. *Sessions*

Sessions devoted to treatment	3,440
Sessions devoted to inspection	236
Sessions devoted to dental health education	11

E. AUDIOLOGY CLINIC AND PRE-SCHOOL HEARING ASSESSMENT CLINIC

New Cases	197	
Cases from previous years still under review	30	
		227
Admitted to the Maud Maxfield School for the Deaf following a period of Auditory Training	17	
Referred to Otologist	20	
Hearing found to be satisfactory	100	
Hearing satisfactory but recommended for Special Therapy	25	
Currently having auditory training	15	
Cases still under review at end of year	97	
Audiometer: pure tone testing		
New cases	753	
Retests	624	
		1377
Sweep tests: ages 6-7 years		
Total		8560
Unsatisfactory and referred to school clinic or general practitoner		425

Peripatetic Staff

	Special	1st & Middle/J.&I.	Secondary	Total
Schools visited ...	13	41	24	78
Children visited ...	44	59	68	171
No. of visits to schools	366	532	312	1210
No. of visits to children ...	574	713	655	1942

F. SPEECH THERAPY CLINIC

Analysis of Work carried out during 1971

Cases open on the 1st January, 1971	385
Cases on waiting list 1st January, 1971	169
Cases referred during 1971	253
	807

Cases closed during 1971	188
Cases open on 31st December, 1971	349
Cases on waiting list 31st December, 1971	
(*a*) not yet seen	66
(*b*) seen for assessment	204
	807

Interviews

Treatment interviews with children	6,263
Supervision interviews with children	812
Diagnostic interviews with children	202
Interviews with parents	662
Interviews with other members of S.H.S.	300
Visits made by Speech Therapists to schools etc.	85
Recall interviews after discharge	1

Children referred for further examination

To Educational Psychologist for mental assessment	6
To Child Guidance Centre for opinion and treatment	3
For E.N.T. examination	7

Reasons for Closure during 1970

I. Treatment Cases

	A	B	C
*1. Good result	2	1	36
2. Maximum benefit	1	3	19
3. Left school or district prior to completion of treatment	4	1	27
4. Non-attendance	1	1	17
5. Parents or patients request	3	1	11
6. Receiving treatment elsewhere	2	—	11

A—Stammer; B—Stammer plus speech defect; C—Speech defect.

*All cases in this category are given a period of supervision prior to closure.

II. Observation Cases

Treatment not indicated after supervision	28
Treatment not indicated at preliminary interview	7

III. Non-attendance at preliminary interview ... 10

IV. Removed from Waiting List ... 2

Number of cases	537
Number of attendances	7,277

G. CHILD GUIDANCE CENTRE

8. Child Guidance Centre

No. of cases open 1st January, 1971				908
No. of cases registered	Boys	407		
	Girls	208		
			615	

Source of reference

Head Teachers	391	
Parent or Guardian	52	
School Medical Officer	102	
Speech Therapist	8	
Juvenile Court	25	
General Practitioner	18	
Hospital...	3	
Others	16	
		615

Reasons for Reference

(i) Nervous Disorders ... ... e.g. fears, shyness, depression, emotional instability, day dreaming	41	
(ii) Habit Disorders ... ... e.g. speech, sleep and feeding disorders, restlessness, incontinence	18	
(iii) Behaviour disorders ... ... e.g. temper, aggression, truancy, delinquency and unmanageability	267	
(iv) Intellectual Difficulties ... ... e.g. educational backwardness and learning difficulties	289	
		615

Age of Reference

Age	2–4	5	6	7	8	9	10	11	12	13	14	15	16	Total
No. of Children	21	45	59	94	89	49	47	48	60	42	41	15	5	615

Analysis of Work

Cases closed		795
Did not attend initially	48	
Consultation only	261	
Supervision only	414	
Treatment cases	72	
Cases open 31st December, 1971		784
Under investigation	69	
Awaiting treatment (investigation completed) ...	189	
Under treatment	31	
Under supervision	495	
Cases on waiting list 31st December, 1971		67

Intelligence quotient range of all cases closed during 1971

	70 and under	71 to 80	81 to 90	91 to 100	101 to 110	111 to 120	121 to 130	Over 130	Not tested	Total
No. of Children ...	68	91	128	147	114	65	20	8	154	795

H. SPECIALIST CLINICS

1. *Ophthalmic*

	Cases	Attendances
Central Clinic		
Errors of refraction	1,602	1,698
Squints	182	192
Congenital Defects	177	193
Inflammatory conditions	10	14
Injuries	2	2
No defects found	119	124
Other Diseases and Defects	—	—
Totals	2,092	2,223
Birley Clinic — Totals		244

2. *Orthoptic (Central Clinic)*

Cases outstanding from 1970	495
New cases: referred	201
registered	179
Cases discharged	127
Cases remaining open	547
Total attendances	1,328
Details of discharges—	
Cured	31
Improved	15
Cosmetically satisfactory	8
No apparent defect	8
After investigation found to be unsuitable	15
Left district	11
Failed to attend	36
Treatment refused	3

3. *Ear, Nose and Throat*

New cases	242
Total seen	401
Total attendances	638
Reasons for attendances:	
Tonsils and adenoids	25
Tonsils	19
Adenoids	177
Otitis media	25
Deafness	162
Other conditions	195
Consultation—no treatment advised at present	35
	638

4. *Orthopaedic*

Children seen	128
Referred to hospital	17
Total attendances	181

5. *Chiropody*

Children seen	968
Treatments given	1907
Under care at end of year	—

J. HANDICAPPED PUPILS

During the calendar year 1971:— Number of handicapped pupils who were:—	(1) Blind (2) Partially Sighted		(3) Deaf (4) Partially Hearing		(5) Physically Handicapped (6) Delicate		(7) Maladjusted (8) Educationally Sub-normal		(9) Epileptic (10) Speech Defects		TOTAL (1)—(10)
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
A. Newly assessed as needing special educational treatment at Special Schools or in Boarding Homes (other than Hospital Special Schools)	1	4	11	10	23	25	25	89	2	1	191
B. (i) Number of these newly placed	1	3	7	9	15	19	22	80	2	1	159
(ii) Placed during the year but assessed prior to 1/1/71 ...	—	—	—	—	1	5	7	41	—	—	54

On 20th January, 1972:— Number of handicapped pupils who were:—	(1) Blind (2) Partially Sighted		(3) Deaf (4) Partially Hearing		(5) Physically Handicapped (6) Delicate		(7) Maladjusted (8) Educationally Sub-normal		(9) Epileptic (10) Speech Defects		TOTAL (1)—(10)
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
C. Requiring places in Special Schools											
(i) TOTAL:—											
(*a*) Day	—	—	—	—	—	—	—	1	—	—	1
(*b*) Boarding	—	—	—	—	2	1	—	1	—	—	4
Number of pupils included in these totals:—											
(ii) Who had not reached the age of 5 and were awaiting:—											
(*a*) Day places	—	—	—	—	—	—	—	—	—	—	—
(*b*) Boarding places	—	—	—	—	—	—	—	—	—	—	—
(iii) Who had reached the age of 5 but whose parents had not consented to their admission to a Special School and awaiting:—											
(*a*) Day places	—	—	—	—	—	—	—	1	—	—	1
(*b*) Boarding places	—	—	—	—	—	—	—	—	—	—	—
(iv) Who had been awaiting admission for more than one year	—	—	—	—	—	—	—	1	—	—	1

HANDICAPPED PUPILS (*continued*)

On 21st January, 1972:— Number of handicapped pupils who were:—	(1) Blind (2) Partially Sighted		(3) Deaf (4) Partially Hearing		(5) Physically Handicapped (6) Delicate		(7) Maladjusted (8) Educationally Sub-normal		(9) Epileptic (10) Speech Defects		TOTAL (1)—(10)
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
D. (i) On the registers of:—											
(1) Maintained Special Schools as:—											
(*a*) Day pupils	—	1	31	4	125	140	103	986	6	23	1,419
(*b*) Boarding pupils ...	8	—	3	—	12	33	5	3	1	—	65
(2) Non-Maintained Special Schools as:—											
(*a*) Day pupils	—	—	—	—	—	—	—	—	—	—	—
(*b*) Boarding pupils ...	4	—	4	—	1	14	4	10	3	2	42
(ii) On the registers of Independent Schools under arrangements made by the Authority... ...	—	—	—	—	—	—	—	—	—	—	—
(iii) Boarded in Homes and not already included under (i) or (ii) above	1	—	—	39	—	7	1	1	—	—	10
(iv) Special Units	—	21	—	—	—	—	—	—	—	—	60
E. Being educated under arrangements made under Section 56 of the Education Act, 1944:—											
(i) In other groups	—	—	—	—	—	—	17	—	—	—	17
(ii) At home	—	—	—	—	11	3	6	3	—	—	23
Total awaiting places or receiving special education	13	22	38	43	151	198	136	1115	10	25	1,641

HANDICAPPED PUPILS (*continued*)

Sheffield Children in Out-of-City Residential Special Schools and Homes, December, 1971

Condition	Boys	Girls	Total
Blind and partially-sighted	3	3	6
Deaf and partially-hearing	2	1	3
Delicate	9	11	20
Educationally sub-normal	12	3	15
Epileptic	1	3	4
Maladjusted	4	2	6
Physically handicapped	—	1	1
Speech defect	2	—	2
	Total ...		57

AGE GROUPS OF CHILDREN ASSESSED DURING 1970

Year of Birth	Age as at 31st Dec.' 71	Not ESN Remain O/S	Review at a later date	E.S.N. old style	E.S.N. new style	Total
1956	15	—	—	—	1	1
1957	14	2	—	1	1	4
1958	13	4	—	5	—	9
1959	12	4	—	6	—	10
1960	11	4	—	6	—	10
1961	10	8	2	10	—	20
1962	9	12	3	11	—	26
1963	8	10	1	21	—	32
1964	7	17	7	18	2	44
1965	6	5	4	8	3	20
1966	5	8	6	10	16	40
1967	4	2	1	4	8	15
		76	24	100	31	231
Total		32·90%	10·39%	43·29%	13·42%	

K. COSTS, Year ended 31st March, 1971

Section	Gross Expenditure	Income	Net Expenditure	Cost in terms of a Penny Rate	
				Gross Expenditure	Net Expenditure
	£	£	£	p	p
Medical Inspection and Treatment	231,947	3,750	228,197	0·97	0·95
Special Schools	1,015,136	355,808	659,328	4·23	2·29
Totals	1,247,083	359,558	887,525	5·20	3·24

City of Sheffield, General Information

Population (as estimated mid-1971) 515,950
Area ... ... 45,363 acres
Density of population ... ... 11·35 persons per acre
Rateable Value at 31st March, 1971 ... ... £24,605,110
Rate levied for Education, year ended 31st March, 1971 ... ... 92·99p
New Penny Rate Product, year ended 31st March, 1971 ... ... £239,791

Primary and Secondary Schools (including Nursery Schools)—
Number of schools 232
Number on rolls 90,998

Special Schools—
Number of schools 23
Number on rolls 2,035

STAFF OF THE SCHOOL HEALTH SERVICE

Medical Officer of Health and Principal School Medical Officer
CLIFFORD H. SHAW, M.D., F.F.C.M., D.P.H., D.P.A.

Deputy Medical Officer of Health and Deputy Principal School Medical Officer
ROGER CHAPMAN, M.B., Ch.B., D.P.H.

Senior School Medical Officer
JOHN C. MacINNES, M.B., Ch.B., M.F.C.M., D.P.H.

Senior Medical Officer (Audiology)
ANNA M. MacCARTHY, M.B., Ch.B.

Full-time School Medical Officers:—
JAMES GREER, L.R.C.P.(1), L.R.C.S.(1), L.M.
MARY B. VINCENT, B.A., M.B., B.Ch., B.A.O., C.P.H.

School Medical Officer also serving the Public Health Service:
KATHERINE S. P. HILL, B.A., M.B., B.Ch., B.A.O.

Joint Appointments to School Health and Public Health Services:
KENNETH W. ALLEN, M.A., M.B., Ch.B., D.Obst., R.C.O.G.
APARNA BANNERJEE, M.B., B.S., D.G.O.
HILARY D. BINGHAM, M.B., Ch.B., D.Obst., D.P.H.
HARRIET G. DORNAN, M.B., Ch.B., B.A.O., D.Obst., R.C.O.G.
B. K. EVANS M.B., Ch.B. (from 6/9/71)
WILLIAM J. GREEN, M.B., Ch.B., D.P.H., (to 31/8/71)
JOHN J. McKESSACK, M.R.C.S., L.R.C.P.
ROSEMARY J. E. SAWORD, M.B., Ch.B., M.R.C.O.G.
D. M. SMALLEY, M.B., Ch.B. (from 6/9/71)
MARY STANNARD, M.B., B.S., M.R.I.C.P. (to 31/7/71)

Part-time School Medical Officers:
*KUMAR CHUGH, M.B., B.S. (from 18/10/71)
*DOREEN C. B. COLVER, M.B., Ch.B., D.C.H.
*MARY P. GRECH, M.B., B.S.
*CHARLES O. GREER, B.A., M.B., B.Ch., B.A.O.
*JOHN A. HOWE, M.B., Ch.B., M.R.C.S., L.R.C.P.
MARION LUNN, M.B., Ch.B., D.P.H.
LYNDA BENSON, L.R.C.P., M.R.C.S. (from 14/9/71)
*MARY E. JEFFERSON, M.B., B.S., M.R.C.P.
*KATHLEEN M. JONES, M.A., M.B., B.Ch., D.C.H.
*SHEILA M. TILLOT, M.R.C.S., L.R.C.P. (to 10/7/71)
*FRANCIS A. WRENCH, M.B., Ch.B.

Specialist Officers:
Ophthalmic Department ... ...†*MALCOLM F. FERGUSON, M.B., B.S., D.O.M.S.
Ear, Nose and Throat Department ... ...†*JOHN T. BUFFIN, B.M., B.Ch., F.R.C.S., D.I.O.
†*R. N. SENN, M.B., B.S., D.O.
Orthopaedic Department ... ...†*ALFORD DORNAN, M.B., Ch.B., F.R.C.S.

Orthoptists:
*Miss JENNIFER A. SMITH, D.B.O.
†*Mrs. N. WAREING, D.B.O.

Chief School Nursing Sister
Miss AUDREY E. SALVIN, S.R.N., S.C.M., H.V.Cert.

School Nursing Sisters:
Mrs. MARY ANDERSON, S.R.N., R.S.C.N.
Miss PHYLLIS A. ARTHUR, S.R.N.
*Mrs. DOREEN ATKINSON, S.R.N. (from 1/1/71)
Mrs. ELIZABETH BATES, S.R.N., R.F.N., C.M.B. (part 1)
Mrs. MARGARET BENNETT, S.R.N.
Mrs. GRACE BROWN, S.R.N., S.C.M.
Mrs. JOYCE COGGINS, S.R.N.
Mrs. BRENDA COSGROVE, S.R.N. (from 7/9/71)
Miss EDITH DONCASTER, S.R.N.
Miss BETTY DRIVER, S.R.N., S.C.M.
Mrs. JEAN SWIFT, S.R.N., S.C.M.
Mrs. BESSIE J. GODDARD, S.R.N.
Mrs. MARY HALL, S.R.N., S.C.M.
Mrs. JOYCE HARDY, S.R.N., R.S.C.N.
Mrs. ANNIE R. HARRISON, S.R.N.
Mrs. IVY HIBBERT, S.R.N., S.C.M.
Miss MARGARET HILTON, S.R.N., R.F.N., C.M.B. (Part 1)
Mrs. PAMELA HOOK, S.R.N. (from 7/9/71)
Mrs. CONSTANCE JONES, S.R.N., C.M.B. (part 1)
Mrs. MARGARET KENNEDY, S.R.N.
Mrs. JACQUELINE KIRKBY, S.R.N.
Mrs. JOYCE LEACH, S.R.N.
Mrs. FLORENCE LEWIS, S.R.N.
Mrs. LILLIAN LIVERSIDGE, S.R.N., T.A. & Orth. Certs.
*Mrs. LOIS McCALLUM, S.R.N., S.C.M.R.F.N., H.V. Cert.
Mrs. J. A. MARSH, S.R.N.
Mrs. ROBERTA A. MAXFIELD, S.R.N.
Mrs. EVELYN NOBLE, S.R.N.
*Mrs. GRACE RICHMOND, S.R.N (p.t. from 11/10/71)
Mrs. SYLVIA ROBINSON, S.R.N.
*Miss GRACE STANIFORTH, S.R.N., S.C.M., (p.t. from 11/10/71)
Mrs. BETTY WILKINSON, S.R.N.
Mrs. JANE WOOD, S.R.N.
Mrs. JOYCE WOOD, S.R.N., C.M.B. (part 1)
Mrs. FLORENCE WARHURST, S.R.N. (from 7/9/71)

Nursing Assistants:

Miss KATHLEEN BELL
Mrs. WINIFRED BLACKWELL
Mrs. SHIRLEY CHILD
Mrs. HAZEL COLLEY
Mrs. MARY CRAPPER, S.E.N.
Mrs. DOROTHY DARWIN
Mrs. CONSTANCE H. ELLIOTT
Mrs. MINNIE ENGLAND, S.E.N.
Mrs. ZONA HEAGNEY
Mrs. GWYNNETH D. MARK
Mrs. BETTY PURVIS, S.E.N.
Mrs. ELIZABETH M. ROSE, S.E.N.
Mrs. JOAN STEER
Mrs. MARY E. TOWNSEND, S.E.N.
Mrs. JOAN M. TURNER
Mrs. LILY WILLIAMS

Pharmaceutical Assistant:

GEORGE WARRILOW

Principal School Dental Officer:

EDGAR COPESTAKE, L.D.S.

Senior School Dental Officers:

NORMAN ANDREWS, B.D.S. (to 31/8/71)
DAVID COOK, B.Ch.D.
Mrs. PETA J. B. HILL, B.D.S. (from 1/9/71)
Mr. GEORGE E. GRIFFITH, L.D.S., D.D.P.H. (from 8/11/71)

School Dental Officers:

Mr. DAVID T. COOTE, B.D.S. (to 31/10/71)
Mrs. JEAN A. FINN, B.D.S. (to 31/10/71)
Mrs. PETA J. B. HILL, B.D.S. (to 31/8/71)
Mr. ROBERT T. KILVINGTON, B.D.S.
Miss MARIA S. PAES, B.D.S. (from 1/10/71)
Miss ANN M. SANDERS, B.D.S. (from 25/1/71)
Mr. ROBIN SCALLY, L.D.S.
Mrs. ANNE E. STIRRUPS, B.D.S. (from 1/11/71)

Dental Anaesthetist:

*COLLETTE TAYLOR, M.B., B.S., D.A., F.F.A.R.C.S.

Dental Auxiliaries:

Mrs. JACQUELINE HARDY
Miss JACQUELINE E. RANDLE (from 1/2/71)

Dental Surgery Assistants:

Miss CLARE L. MARSDEN (Senior)
Mrs. MARGARET BENTLEY
Mrs. ESME BROOK (to 31/8/71)
Mrs. LILLIAN BUTLER
Miss PATRICIA GINGELL
Miss ANN M. GREAVES (from 6/9/71)
Miss ELIZABETH A. HAMMOND
Miss JULIE M. PAGE (from 27/4/71)
Miss PATRICIA REID
Mrs. AUDREY ROSS
Mrs. MOIRA SHEPPARD (from 27/4/71)
Mrs. SUSAN E. SIDDALL
Mrs. JOYCE WHITEHEAD
Mrs. CAROLE WORRALL (to 31/12/71)

Dental Technician:

CLIFFORD J. ATKIN (Senior)

Child Guidance Centre:

Medical Director—THE SENIOR SCHOOL MEDICAL OFFICER

F. DAVID LOXLEY, B.A., A.B., Pf.S., (Senior Educational Psychologist)
Mrs. JUDITH A. BENNISON, B.A. (Educational Psychologist)
Mrs. MAUREEN J. BIRCH, B.A. (Educational Psychologist)
Miss VALERIE A. GREAVES, B.A. (Educational Psychologist)
Mrs. MARGARET A. HAMIDI, B.Sc. (from 4/10/71) (Trainee Educational Psychologist)
JOHN B. HARRISON, B.A. (from 28/6/71) (Educational Psychologist)
*Mrs. JACQUELINE A. JACKSON, B.A. (from 1/3/71) (Educational Psychologist)
*Mrs. KATHLEEN M. PRESTON, B.A. (Educational Psychologist)
Mrs. JACQUELINE M. RUDDOCK, B.A. (Educational Psychologist)
DAVID A. THOMPSON, B.A. (from 1/11/71) (Educational Psychologist)
†*R. A. BUGLER, M.B., B.S., D.P.M. (Psychiatrist)
†*F. G. THORPE, M.A., Ch.B., D.P.M. (Psychiatrist)
†*REGINALD WARNECKE, M.R.C.S., L.R.C.P., D.P.M. (Psychiatrist)
†*A. C. WOODMANSEY, M.D., M.R.C.P., D.P.M., D.C.H. (Psychiatrist)
K. DAWSON-BUTTERWORTH, M.R.C.S., L.R.C.P. D.P.M. (Psychiatrist)
Miss ROSALIND M. ARCHBELL (from 1/2/71) (Social Worker)
*Mrs. CHAJE R. HOLMES (Psychiatric Social Worker)
*Mrs. CECILIA M. RILEY, B.A. (Social Worker)

Speech Therapy Clinic:

Miss ANNE B. CHAPMAN, L.C.S.T. (Senior Speech Therapist)
*Mrs. ANGELA BAKER, L.C.S.T.
*Mrs. ANNE D. M. GRAY, L.C.S.T.
Miss CHRISTINE W. HOLLAND, L.C.S.T.
Mrs. BRENDA JEYNES, L.C.S.T. (to 31/8/71)
Miss JANE SCOTT, L.C.S.T. (to 30/5/70)
Miss JEAN THACKERAY, L.C.S.T. (from 1/9/70)

Chiropodist:

*LEONARD ALDAM, M.Ch.S., S.R.Ch.

Bents Green School:

Miss EILEEN MAGEE, S.E.N. (Assistant Nurse)

Chantrey School:

Mrs. OLGA M. BANNISTER
(Physiotherapist)
Mrs. THEODORA W. N. COLQUHOUN
(Senior Physiotherapist)
Mrs. HEATHER V. HAYWOOD
(Physiotherapist)
Mrs. MARGARET HOLMES
(Physiotherapist Helper)

Mrs. MARION FORTESCUE, S.R.N.
(Resident Nurse)
Mrs. BESSIE FURNESS, S.E.N.
(Assistant Nurse)
Miss NORA BELL, S.E.N.
(Assistant Nurse)
Mrs. J. HAWKESWORTH, (from 21.6.71)
(Physiotherapist)

Mossbrook School:

Mrs. THEODORA M. DAVIS
(Senior Physiotherapist)
Mrs. IRENE M. IVINSON
(Physiotherapist)
Mrs. KATHLEEN L. WINDLE, S.R.N. (to 31/10/71)
(Senior Resident Nurse)
Mrs. NELLIE KENNEDY, S.E.N.
(Assistant Nurse)

Mrs. MARY E. MERRILL, S.E.N.
(Assistant Nurse)
Mrs. GLORIA M. DAY, S.R.N. (from 19/10/70)
(Senior Resident Nurse)
Mrs. VIVIENNE L. KYLE, S.R.N. (from 7/9/71)
(Resident Nurse)

SCHOOL HEALTH SERVICE, Central Clinic, 7 Leopold Street, S1 2GY

(NOTE: * Denotes part-time officer; † Denotes appointment by arrangements with the Regional Hospital Board).

SPECIAL SCHOOLS

	Accommodation for
Blind	
Tapton Mount School	80 pupils (res)
Partially Sighted	
Brook School (Special Unit)	15 pupils (day)
Stradbroke County School (Special Unit)	15 pupils (day)
Deaf (Grade III) and Partially Hearing (Grade IIB)	
Maud Maxfield School	36 pupils (res) 64 pupils (day)
Partially Hearing (Grade IIA)	
East Hill (Special Unit)	16 pupils (day)
Greystones First School (Special Unit)	20 pupils (day)
Greystones Middle School (Special Unit)	20 pupils (day)
King Ecgbert Comprehensive School (Special Unit) ...	20 pupils (day)
High Storrs Comprehensive School (Special Unit) ...	10 pupils (day)
Delicate	
Bents Green School	42 pupils (res) 170 pupils (day)
Whiteley Wood School	144 pupils (day)
Physically Handicapped	
Chantrey School	40 pupils (res) 20 pupils (day)
Mossbrook School	50 pupils (res) 10 pupils (day)
Oakes Park School	120 pupils (day)
Educationally Subnormal (Old Style)	
East Hill Schools	
Junior and Infant	100 pupils (day)
Senior	120 pupils (day)
Handsworth/Carbrook School	
Junior and Infant	150 pupils (day)
Highfield School	
Senior	120 pupils (day)
Springvale House	
Junior and Infant	80 pupils (day)
Wadsley Bridge Schools	
Junior and Infant	100 pupils (day)
Senior	120 pupils (day)
Educationally Subnormal (New Style)	
Norfolk Park School	110 pupils (day)
Norfolk Park Special Care Unit	40 pupils (day)
Norfolk Park Short Stay Hostel	8 pupils (res)
Talbot School	120 pupils (day)
Woolley Wood School	100 pupils (day)
Maladjusted	
Broad Elms	50 pupils (day)
Learning Difficulties	
Kirkhill School	50 pupils (day)
Schools run in conjunction with other bodies	
Shirle Hill School	20 pupils
Todwick Grange	30 pupils
School Leavers' Work Preparation Course	15 pupils (every 4 months)

CLINICS

Clinic	No. of Schools	Times of Attendance
Specialist and Administrative Centre, Central Clinic, 7, Leopold Street	All	Full-time
Audiology Clinic, Orchard Lane	All	Full-time
CHILD GUIDANCE CENTRES:		
9, Newbould Lane	All	Full-time
Handsworth Clinic, Hall Road	22	Thurs. mornings
Catchbar Lane	25	Fridays all day
Hackenthorpe	14	Mon. afternoons
SPEECH THERAPY CLINICS:		
Catchbar Lane	All	Full-time
Attercliffe Clinic, Vicarage Road	24	Thurs. afternoons
Greenhill Clinic, Greenhill County School	11	Wed. mornings
Manor Clinic, Prince Edward County School ...	57	Tues., Thurs. and Fri. mornings
Manor Welfare Centre, Ridgeway Road ...		Tues. afternoons
9, Newbould Lane	44	Fri. afternoons
DISTRICT MEDICAL CLINICS:		
Attercliffe Clinic, Vicarage Road	16	Wed. mornings
Central Clinic, 7, Leopold Street—District E	12	Wed. afternoons and Sat. mornings
District F	38	Mon. and Thurs. afternoons and Sat. mornings
Chaucer Clinic, Chaucer Comprehensive School ...	21	Mon. Wed. mornings
Frecheville Clinic, Fox Lane	10	Wed. mornings
Greenhill Clinic, Greenhill County School	16	Mon afternoons.
Hackenthorpe Clinic, Main Street	10	1st & 3rd Tues. afternoons of every month
Handsworth Clinic, Hall Road	10	Wed. mornings
Heeley Clinic, Lowfield County School	25	Tues. and Fri. afternoons
Manor Clinic, Prince Edward County School	31	Mon. and Thurs. afternoons
Myers Grove Clinic, Myers Grove School	6	Tues. mornings
Pitsmoor Clinic, Ellesmere Road County School ...	12	Thurs. afternoons
Shiregreen Clinic, Shiregreen County School	14	Mon. mornings
Wisewood Clinic, Wisewood County School	6	Thurs. mornings
Woodhouse Clinic, Chapel Street	7	Fri. afternoons
Wybourn Clinic, Wybourn County School	4	Tues. afternoons

Clinic	No. of Schools	Times of Attendance
DENTAL CLINICS:		
Central Clinic, 7, Leopold Street	77	Varies
Heeley Clinic, Lowfield County School	28	,,
Gleadless Welfare Centre, White Lane	14	,,
Hackenthorpe Welfare Centre, Main Street	9	,,
Rowlinson Clinic, Rowlinson Technical School ...	13	,,
Attercliffe Clinic, Vicarage Road	16	,,
Owler Lane Clinic, Owler Lane County School ...	14	,
Hatfield Clinic, Hatfield Comprehensive School ...	15	,,
Manor Clinic, Prince Edward School	39	,,
Mobile Dental Clinic	9	,,
Wheata Place Clinic	16	,,

City of Sheffield Printing Department